MEDICAID MEMO

TO: All Providers Participating in the Virginia Medicaid and FAMIS Programs

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 12/29/2017

SUBJECT: Commonwealth Coordinated Care Plus Managed Care Program-
Coordination with Medicare

The purpose of this memo is to inform providers of the coordination of benefits between Medicare and Medicaid under the Commonwealth Coordinated Care Plus (CCC Plus) program. Dual eligible members are one of the Commonwealth's most vulnerable populations. DMAS respectfully requests that providers continue to serve these members without interruption. DMAS and the CCC Plus Health Plans have worked collaboratively to streamline the billing process for Medicare providers. Under CCC Plus, the individual's Medicare carrier continues to pay as the primary payer, and the CCC Plus plan will coordinate and pay any remaining coinsurance and deductibles, up to the Medicaid allowable. The provider is not required to be in the CCC Plus Plan's network or to obtain an authorization from the Plan for crossover claim payment.

BACKGROUND

Since 2011, the Virginia General Assembly has shown bipartisan support, through mandated budgetary language, to transition all Medicaid enrollees from the fee-for-service delivery model into the Managed Care Model to achieve high quality care and budget predictability. DMAS is currently transitioning over 216,000 individuals into CCC Plus. CCC Plus coverage is statewide and participation is required for eligible populations. Over half of these individuals are dually eligible for Medicare and Medicaid; however, CCC Plus is strictly a Medicaid program. The individual's Medicare carrier continues to provide primary coverage for the dual individual's Medicare covered services (i.e., physician visits, hospital stays, outpatient services, home health, prescription drugs, etc.).

MEDICARE DELIVERY MODELS

Individuals with dual coverage may obtain Medicare coverage in one of three ways: Fee-for-Service Medicare, Medicare Advantage Plan, or a Dual Special Needs Plan (D-SNP). CCC Plus members may continue to choose any of these delivery systems for their Medicare services. CCC Plus members are not required to receive their Medicare coverage through a D-SNP.

Dual eligible CCC Plus members will have coverage for their Medicaid benefits through a CCC Plus Health Plan. If a member has **Medicare and Medicaid**, their existing **Medicare coverage and providers do _not_ have to change**. Individuals can maintain coverage through their current Medicare plan, including through their current Medicare providers.

COORDINATION OF BENEFITS
DMAS and the CCC Plus Health Plans have streamlined the billing process for Medicare providers. The Plan will not require the Medicare provider to be in their network or to obtain an authorization prior to payment of Medicare crossover claims. CCC Plus Health Plans will pay up to the Medicaid allowable for crossover claims, including coinsurance and deductibles, for individuals with both Medicare and Medicaid. In the event that Medicare denies coverage, the CCC Plus plan may require an authorization as the primary payer.

BALANCE BILLING OF DUALS IS PROHIBITED
Federal regulations prohibit providers from balance billing dual eligible members. Medicare providers must agree to accept payment from Medicare and Medicaid (if any), including the crossover payment by the CCC Plus Medicaid plan, as payment in full. If any Medicare provider bills a dual eligible member, he/she will be in violation of their Medicare Provider Agreement and may be subject to sanctions (per Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A) of the Social Security Act). Pharmaceuticals covered under Medicare Part-D are non-covered under Medicaid; therefore, the CCC Plus Plan is not responsible for the Medicare Part-D copayment.

Additional details regarding the CMS prohibition on billing dual eligible individuals is provided by the Center for Medicare and Medicaid Services in the communication available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

MEDICAID ELIGIBILITY
In order to identify the Member's CCC Plus Health Plan, the provider may use the DMAS web portal eligibility verification system or MediCall. Please see Appendix A of this memo for tips on how to identify the Member's health plan. Providers are encouraged to verify eligibility and enrollment at the time of service.

BILLING CROSSOVER CLAIMS
CCC Plus Health Plans are working diligently to finalize their Coordination of Benefits Agreement (COBA) with CMS for Medicare fee-for-service. Once COBA is in place, claims submitted by providers to Medicare fee-for-service will automatically crossover to the Member's CCC Plus Plan for the Medicaid portion of the claim. Providers will be notified when the COBA process is implemented.

Until COBA is implemented, providers will need to submit the Medicare Explanation of Benefits (EOBs) to the Member's health plan for crossover claim payment. As COBA only applies for Medicare fee-for-service, for Members with Medicare Advantage or D-SNP coverage, providers will need to submit EOBs to the Member's health plan for crossover claim payment. See Appendix B of this Memo for how to bill a CCC Plus Health Plan as an out of network provider.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)
Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and

credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS
Many Medicaid individuals are enrolled in one of the Department's managed care programs (Medallion 3.0, CCC and PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. Streamlined processes are in place for individuals who are dually eligible for Medicare and Medicaid. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

> ➢ Medallion 3.0:
> http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
> ➢ Commonwealth Coordinated Care (CCC):
> http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
> ➢ Commonwealth Coordinated Care Plus (CCC Plus):
> http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
> ➢ Program of All-Inclusive Care for the Elderly (PACE):
> http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

VIRGINIA MEDICAID WEB PORTAL
DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL
Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"
The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html

Appendix A
Tips on How to Identify the Member's Managed Care Plan

Below are screenshots from the Virginia Medicaid Web Portal, member eligibility inquiry look-up system (known as ARS) through Medicaid Management Information System (MMIS). More information regarding ARS can be found here (this link may not work if you are not registered MMIS user). A member's status, including Medicaid eligibility, program (CCC, CCC Plus, Medallion, etc.) enrollment and health plan assignment are updated monthly. Please check member's status on the first of each month to verify their current eligibility and enrollment.

CCC Plus Member:

Plan Description - CoPay Indicator ▲	Plan From ▲	Plan To ▲	Provider ID ▲	Provider Name ▲	Provider Phone ▲
AGED WAIVER - B	10/01/2017	10/31/2017			
XIX CCCP CW	10/01/2017	10/31/2017	0247726240	VIRGINIA PREMIER HEALTH PLAN, INC.	877-719-7358
MEDICAID FFS	10/01/2017	10/31/2017			

Showing 1 - 3 of 3

See "XIX CCCP" under "Plan Description", circled above. Note: Members transitioning to CCC Plus on 1/1/2018 from other managed care programs (i.e., Medallion or CCC) will continue to show enrollment with the prior managed care program through 12/31/2017.
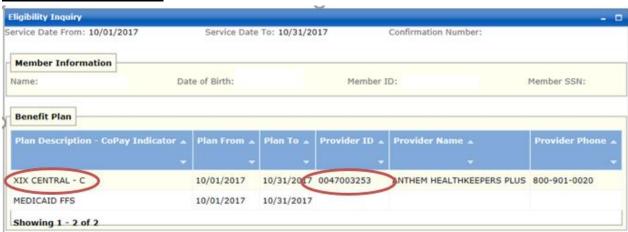
CCC Member

Plan Description - CoPay Indicator ▲	Plan From ▲	Plan To ▲	Provider ID ▲	Provider Name ▲	Provider Phone ▲
MEDICAID FFS - C	10/01/2017	10/31/2017			
CCC MMP	10/01/2017	10/31/2017	0173025666	HEALTHKEEPERS, INC	855-817-5788
MED CO & DED	10/01/2017	10/31/2017			

Showing 1 - 3 of 3

See "CCC MMP" under "Plan Description", circled above. Members enrolled in CCC will continue to show CCC enrollment through 12/31/2017. CCC Plus enrollment (see below) will not show up until 01/01/2018.

Medallion 3.0 Member:

Unlike CCC and CCC Plus, Medallion 3.0 is not identified by acronym under Plan Description. Members enrolled in Medallion 3.0 and assigned to CCC Plus for 1/1/2018 will continue to show Medallion enrollment through 12/31/2017.

Appendix B
Submitting Claims to CCC Plus Health Plans as a Non-Participating Provider

Aetna Better Health	If no provider information exists and a claim comes in, we will set up the provider as non-par and contract based upon program rules. For standard non-par setup, all information required is included in the claim from the provider. The provider will be paid at 100% of the DMAS rate and may not balance bill the member.
Anthem HealthKeepers Plus	A provider does not have to do anything in particular as long as they agree to be paid at 100% of the DMAS rate. Our system is configured to pay non-par provider at 100% of the DMAS rate. Out of Network providers who want to be paid via EFT will need to have registered with Anthem through CAQH. The provider will be paid at 100% of the DMAS rate and may not balance bill the member.
Magellan Complete Care of VA	As long as a provider, par or non-par, is registered with DMAS we are able to process and pay their claims with no additional information beyond provider demographic claim data. If the registered non-par provider submits via EDI, we are able to accept their claims via a clearinghouse. If they are enrolled in EFT via CAQH, we are able to submit payment via the EFT process. The provider will be paid at 100% of the DMAS rate and may not balance bill the member.
Optima Health Community Care	In order to process claims from non-participating providers the provider must submit: Provider Name, Address, Provider Tax ID #, Provider NPI, Provider Taxonomy (if known). The provider will be paid at 100% of the DMAS rate and may not balance bill the member.
UnitedHealthcare Community Plan	We do not need any IRS documents for EFT or Checks. All claims can be paid via information included on an incoming claim file. Should there be any information discrepancy on demographics in our system and the incoming claim, a call will be made to request a W-9 from the provider. The provider will be paid at 100% of the DMAS rate and may not balance bill the member.
Virginia Premier Elite Plus	All Providers will need to submit a W-9 for payment. Electronic submitters will need to submit an EDI enrollment form which is available on our website. Providers will be paid at 100% of the DMAS rate and may not balance bill the member. ARTS providers will also need to submit an attestation of their ASAM level. Early Intervention providers will also need to submit attestation of their certification if we cannot confirm certification from EI Rosters.